Commonwealth of Virginia Retiree Health Benefits Program

Medicare-Coordinating Plan Options

Effective January 1, 2020

A10229 (11/2019)

COMPARISON OF MEDICARE AND STATE SUPPLEMENTAL PLANS

Use the chart on pages one and two to review Medicare's benefits and the supplemental/Medicare-coordinating plan benefits available to State Retiree Health Benefits Program participants who are eligible for Medicare.

More information about optional prescription drug, dental and vision benefits are summarized on pages 3-5.

Part A Services	Medicare
Hospital Inpatient *(medical)*	• Pays up to 60 days of medically necessary services, except Part A hospital deductible • Pays up to an additional 30 days, except daily coinsurance • If more than a 90-day hospital stay, can pay up to 60 Medicare lifetime reserve days, except daily coinsurance • No payment for more than a 90-day hospital stay per benefit period if no lifetime reserve days remain or if you choose not to use them
Skilled Nursing Facility	• Pays 100% for 20 days at a Medicare-certified skilled nursing facility • Pays up to an additional 80 days at a skilled nursing facility, except daily coinsurance • Medicare does not pay for more than 100 days at a skilled nursing facility in a benefit period
Part B Services	**Medicare**
Physician And Other Services	• Generally pays 80% of Medicare-approved charges for services such as a doctor's care and outpatient physical or occupational therapy (within limits). Certain screenings and wellness/preventive services are covered at no cost – see your "Medicare and You" publication for more information. • An annual deductible may apply
Part D Services	**Medicare**
Prescription Drug Coverage	• Pays a benefit based on the specific Part D plan in which the beneficiary is enrolled
Other Services	**Medicare**
Routine Vision Benefits	• Not covered
Routine Dental Benefits	• Not covered
Routine Hearing Benefits	• Not covered
Out-Of-Country And Major Medical Services	• Not covered
At Home Recovery Care And Visits	• Not covered

Note: *This chart is meant to provide a basic overview of Original Medicare coverage and the supplemental plans available under the state program. The Medicare-Coordinating Plans Member Handbook and applicable inserts, available at* ***www.dhrm.virginia.gov****, include detailed information about benefits, exclusions, limitations and your responsibilities under these plans.*

	Advantage 65	**Advantage 65 – Medical Only**
	• *Pays Medicare Part A deductible except for first $100* • *Pays Medicare Part A coinsurance* • *Pays 100% of allowable charge for eligible expenses for an additional 365 days*	• *Pays Medicare Part A deductible except for first $100* • *Pays Medicare Part A coinsurance* • *Pays 100% of allowable charge for eligible expenses for an additional 365 days*
	• *Pays Medicare Part A coinsurance (days 21-100)* • *Pays above coinsurance amount for an additional 80 days per Medicare benefit period*	• *Pays Medicare Part A coinsurance (days 21-100)* • *Pays above coinsurance amount for an additional 80 days per Medicare benefit period*
	Advantage 65	**Advantage 65 – Medical Only**
	• *Does not pay Medicare Part B deductible, but does pay Part B coinsurance*	• *Does not pay Medicare Part B deductible, but does pay Part B coinsurance*
	Advantage 65	**Advantage 65 – Medical Only**
	• *Enhanced Medicare Part D plan – see pages 4-5*	• *Does not include outpatient prescription drug coverage – once this plan is elected, participants may not elect a state program Medicare-coordinating plan with prescription drug coverage at a later date* • *Participants may elect drug coverage through another (non-state program) Medicare Part D plan or other creditable coverage*
	Advantage 65	**Advantage 65 – Medical Only**
	• *Optional – see page 3*	• *Optional – see page 3*
	• *Optional – see page 3*	• *Optional – see page 3*
	• Pays for one routine hearing test every 48 months, except for $40 copayment • Pays up to $1,200 toward the cost of hearing aids and supplies every 48 months	• Pays for one routine hearing test every 48 months, except for $40 copayment • Pays up to $1,200 toward the cost of hearing aids and nd supplies every 48 months
	For Out-Of-Country services only: • *Pays 80% of allowable charge after you pay $250 calendar year deductible*	**For Out-of-Country services only:** • *Pays 80% of allowable charge after you pay $250 calendar year deductible*
	• *Pays up to $40 per visit, not to exceed $1,600 each calendar year and 7 visits each week*	• *Pays up to $40 per visit, not to exceed $1,600 each calendar year and 7 visits each week*

DENTAL/VISION OPTION

Dental/Vision coverage may be added to Advantage 65 or Advantage 65—Medical Only at any time, and it may be cancelled at any time. However, once the Dental/Vision option has been elected and cancelled one time under any Medicare-coordinating plan, it may not be elected again. When adding Dental/Vision, your election will be effective the first of the month following receipt of your request.

Dental Benefits	**The Plan Pays:**
The maximum benefit per calendar year is $2,000 per enrollee. There is no annual deductible. Some limitations may apply. See your Dental/Vision Member Handbook Insert for additional information.	
Diagnostic and Preventive Care, including: • Two routine oral evaluations, cleanings and bitewing x-rays per calendar year • One full mouth x-ray every three years	100% of the allowable charge
Basic Dental Care, including: • Fillings *(amalgam or composite resin)* • Simple extractions of natural teeth and surgical extractions of fully-erupted teeth • Root canal therapy (endodontic) • Repair of broken removable dentures • Re-cementing existing crowns, inlays and bridges *(once every 12 months – some limitations may apply)*	80% of the allowable charge
Major Dental Care, including: • Crowns (single crowns, inlays and onlays) • Prosthodontics *(partials or complete dentures and fixed bridges - once every five years)* • Dental Implants *(once every five years)*	5% of the allowable charge
Vision Benefits	**The Member Pays or Plan Allows:**
The following benefits apply to network providers. Your Dental/Vision Member Handbook Insert provides out-of-network benefit levels.	
Routine Vision Examination *(once each plan year)*	$20 copayment *(network provider)*
Eyeglass frames *(once each plan year)*	$100 allowance and 20% off remaining balance *(network provider)*
Eyeglass lenses *(one of the following each plan year)* • Standard plastic single vision lenses *(one pair)* • Standard plastic bifocal lenses *(one pair)* • Standard plastic trifocal lenses *(one pair)* • Standard progressive lenses *(one pair)* **OR** **Contact Lenses** *(one of the following each plan year)* • Elective conventional contact lenses • Elective disposable contact lenses • Non-Elective contact lenses **Eyeglass lens upgrades** • UV Coating • Tint *(solid and gradient)* • Standard scratch-resistance • Standard polycarbonate • Standard anti-reflective coating • Other add-ons and services	 $20 copayment *(network provider)* $20 copayment *(network provider)* $20 copayment *(network provider)* $85 copayment *(network provider)* $100 allowance and 15% discount off remaining balance *(network provider)* $100 allowance *(network provider - no additional discount)* $250 allowance *(network provider - no additional discount)* $15 *(network provider)* $15 *(network provider)* $15 *(network provider)* $40 *(network provider)* $45 *(network provider)* 20% off retail price *(network provider)*

Use of a non-participating provider will generally result in a reduced benefit and higher out-of-pocket costs. Your Member Handbook Dental/Vision Insert includes additional information.

ENHANCED MEDICARE PART D PLAN OPTION

Effective January 1 – December 31, 2020

Participants covered under the Advantage 65 Plan or Advantage 65 + Dental/Vision Plan will have the outpatient prescription drug coverage described below (pending Medicare approval). The level of coverage is based on:

- *Whether the drug is included on the plan's formulary — the list of covered drugs for the current plan year which is available at **www.express-scripts.com/documents** or by calling Customer Service at 1-800-572-4098 (TTY users call 1-800-716-3231)*
  - *Generally, drugs that are not on the plan's formulary will not be covered; however additional information regarding exceptions is provided in the Evidence of Coverage.*
- *The coverage tier of the drug — tiers are described in the chart below and are designated for all covered drugs in your formulary*
- *The coverage stage — each coverage stage is described below*

Deductible Stage – *A $435 annual deductible will apply to covered brand-name drugs. There is no deductible for covered generics.*

Initial Coverage Stage – *Once the annual deductible has been met for covered brand-name drugs (and immediately for covered generics), the Initial Coverage Stage will provide the following benefit until total drug cost reaches $4,020:*

Drug Tier	Supply of Medication/ Method of Purchase	Your Copayment/Coinsurance Amount
Tier 1 Generics	Up to a 34-day supply of a covered generic drug at a participating retail pharmacy	$7.00
Tier 1 Generics	Up to a 90-day supply of a covered generic drug purchased through the mail service program	$7.00
Tier 2 Preferred Brands	Up to a 34-day supply of a covered preferred brand drug at a participating retail pharmacy	$25.00 (after deductible)
Tier 2 Preferred Brands	Up to a 90-day supply of a covered preferred brand drug purchased through the mail service program	$50.00 (after deductible)
Tier 3 Non-Preferred Brands	Up to a 34-day supply of a covered non-preferred brand drug at a participating retail pharmacy	75% of the cost of the drug (after deductible)
Tier 3 Non-Preferred Brands	Up to a 90-day supply of a covered non-preferred brand drug purchased through the mail service program	75% of the cost of the drug (after deductible)
Tier 4 Specialty Drugs	Up to a 34-day supply of a covered specialty drug at a participating retail pharmacy	25% of the cost of the drug (after deductible)
Tier 4 Specialty Drugs	Up to a 90-day supply of a covered specialty drug purchased through the mail service program	25% of the cost of the drug (after deductible)

Coverage Stages *continued on page 5*

Coverage Gap Stage – This plan does not have a coverage gap. *After your total drug costs reach* **$4,020** *in the 2020 plan year (the point at which standard plans reach their Coverage Gap), this plan will generally cover generic and formulary brand-name drugs at the same copayment or coinsurance as in the Initial Coverage Stage. However, due to the Medicare Coverage Gap Discount Program, the amount you pay for non-preferred drugs may be lower. You will stay in this stage until your out-of-pocket drug cost plus the amount paid by the Coverage Gap Discount Program for this plan year reaches* **$6,350**. *The plan's Evidence of Coverage has complete information.*

Catastrophic Coverage Stage – *In 2020, if your annual true out-of-pocket drug expense (including deductible, copayments, coinsurance, and the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches* **$6,350**, *you will pay the greater of either 5% coinsurance or a copayment of* **$3.60** *(generics or drugs treated as generics) or* **$8.95** *(brand-name drugs). You will remain in this stage for the remainder of the year.*

Medicare Explanation of Benefits (EOB) – *To help participants track their coverage stages, an EOB is provided by the claims administrator for any months during which their benefit is used. You may also obtain a copy electronically by accessing the website at* ***www.express-scripts.com*** *or by contacting Express Scripts Medicare Customer Service at 1-800-572-4098, TTY callers1-800-716-3231.*

Your **Evidence of Coverage** *provides more detailed information about this prescription drug coverage. You may request a copy of this document from Express Scripts Medicare by contacting Customer Service at 1-800-572-4098 (TTY users call 1-800-716-3231) or by visiting their website at* ***www.express-scripts.com/documents***.